

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/26/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/12/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CADIA REHABILITATION RENAISSANCE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>26002 JOHN J WILLIAMS HIGHWAY</b> <b>MILLSBORO, DE 19966</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced follow-up survey, for the annual and complaint survey ending September 6, 2018, was conducted at this facility from December 11, 2018 through December 12, 2018. The facility census the first day of the survey was 118. The survey sample totaled 18 records. The survey process included observations, interviews, review of residents' clinical records and other documentation as indicated.</p> <p>The facility was in substantial compliance with 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities as of December 12, 2018.</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/19/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Health Care Quality

Office of Long Term Care

Protection

Residents

**STATE SURVEY REPORT  
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DHSS - DHCQ  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**NAME OF FACILITY:** Cadia Rehabilitation Renaissance  
2018

**DATE SURVEY COMPLETED:** December 12,

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced follow-up survey, for the annual and complaint survey ending September 6, 2018, was conducted at this facility from December 11, 2018 through December 12, 2018. The facility census the first day of the survey was 118. The survey sample totaled 18 records. The survey process included observations, interviews, review of residents' clinical records and other documentation as indicated.</p>		
3201.1.0	<p><b>Regulations for Skilled and Intermediate Care Facilities</b></p>		
3201.1.2	<p><b>Scope</b></p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is met as evidenced by the following: No deficiency was cited at the time of the survey.</p>		

Provider's Signature

*Joyce Winters*

Title

*NHA*

Date

*12/19/18*